CHAPTER 11
SECTION 3

DUPLICATE CLAIMS DATA

The Duplicate Claims System performs several functions for the maintenance of the Duplicate Claims Database. First, it identifies, selects, and extracts potential duplicate claims from the Health Care Service Records (HCSRs) database. It then groups potential duplicate claims into sets and stores these claims in the Duplicate Claims Database. Subsequently, it identifies adjustment and cancellation transactions processed by the HCSR system associated with claims in the Duplicate Claims Database and attaches these adjustment transactions to their associated sets. In attaching adjustment/cancellation HCSR transactions to their associated sets, the system enables users to verify that duplicate payment records have been removed from the HCSR database.

The Duplicate Claims System performs these functions separate and apart from the proprietary, claims processing systems maintained by each Fiscal Intermediary and Managed Care Support Contractor. Proprietary, claims processing systems maintain claim and encounter processing histories which document the activities associated with the processing and payment of claims and encounters. These systems generate HCSRs for submission to the TMA. HCSRs reflect specific claim/encounter processing activity and document health care services and associated payment actions. HCSRs are in a uniform format to permit claims processing data from various contractors to be integrated into a single database.

As stipulated in all TRICARE claims processing contracts and in the Operations Manual (OPS), contractors are required to prevent duplicate claim payments. Despite a variety of automated and manual controls established for this purpose, duplicate payments are made. These duplicate payments, appearing as duplicate HCSRs, are detectable by TMA. When duplicate payments are identified, contractors are expected to initiate recoupment action. Upon receipt of the refunds or offsets, adjustment HCSRs should be submitted to reflect the recoupment. When adjustments are added to the HCSR database, the duplicate payment is corrected, and the duplicate condition is removed from the HCSR database.

The correction of the HCSR database is a critical function of the Duplicate Claims System. Not only do duplicate HCSRs represent overpayments, their very existence in the HCSR database skew statistics and reduce the confidence of analyses and projections based on this data. Data integrity is compromised if the database is not purged of HCSRs representing duplicate payments.

1.0. SOURCE OF DUPLICATE CLAIMS DATA

The Duplicate Claims Database receives HCSR data through two extracts. The first extract is performed monthly, when HCSRs submitted by contractors during the previous month are compared with HCSRs submitted during the previous 12 months. Applying five different match criteria for institutional and non-institutional claims (four for each type), the

system detects potential duplicate claims and selects these for extraction. See Section B., Criteria Used to Select Potential Duplicate Claims, for a description of the five match criteria.

Institutional potential duplicates are identified by the application of the match criteria at the claim level. Non-institutional potential duplicates are identified at the line item level. This distinction is important in understanding how institutional and non-institutional claims are displayed within the claim sets. Refer to Section IV., Claim Sets and the Claim Set Life Cycle, for details regarding claim set composition. The second extract is performed following the processing of each payment record cycle, generally on a daily basis. The system maintains a table of all claims selected as potential duplicates during the first extract, and extracts adjustments and cancellations associated with these potential duplicates during the second extract.

The Duplicate Claims Database stores claim level data for both institutional and non-institutional claims. Examples of claim level data are: ICN, sponsor social security number, diagnosis code, care begin and end dates (institutional only), claim billed amount, claim allowed amount and claim Government paid amount.

The system also stores line item data for non-institutional claims. Examples of line item detailed data are: procedure code, place of service, type of service, care begin and end dates, line item billed amount and line item allowed amount.

Addendum A, Duplicate Claims System Data Fields, contains a description of the data elements in the Duplicate Claims Database.

2.0. CRITERIA USED TO SELECT POTENTIAL DUPLICATE CLAIMS

The Duplicate Claims System uses the criteria described on the following pages to extract HCSR data and load the Duplicate Claims Database. The Duplicate Claims System inspects up to 14 HCSR data fields in each claim record and, if the claims match on one of the criteria categories, it extracts and groups these claims into sets. The criteria used by the system identifies claims with a high probability of being actual duplicates.

2.1. Match Criteria for Institutional Claims

The following categories of match criteria are used to identify and link two or more matched institutional claims. Figure 11-3-1, Data Field Match Criteria for Institutional Claims, (on the following page), shows the specific HCSR data field match criteria used to select potential institutional duplicate claims.

Exact Match — All 14 fields match.

Near Match — Six fields match and the lesser Billed Amount is within 10 percent of the larger Billed Amount.

Date Overlap — Four fields match and the beginning date of care of one claim falls between the beginning and ending dates of another.

Other — Five fields match.

FIGURE 11-3-1 DATA FIELD MATCH CRITERIA FOR INSTITUTIONAL CLAIMS

FIELD NAME	EXACT MATCH	NEAR MATCH	DATE OVERLAP	OTHER
SPONSOR SSAN	✔	✔	✔	✔
DEERS DEPN SUFFIX	✓	✔	✔	✔
PATIENT DOB	✔			
PROGRAM INDICATOR	✔			
PROVIDER TAX ID	✔	3	✔	✔
PROVIDER SUB ID	✔	3	✔	✔
ADMIT DATE	✔			
BILL FREQUENCY	✔			
BILLED AMOUNT	✔	+ / - 10% *		
ALLOWED AMOUNT	✔			
CARE BEGIN DATE	✔	✔	OVERLAP	✔
CARE END DATE	✔	✔		
PRIN DIAGNOSIS	✔			
DRG CODE	✔			

NOTE: * The system calculated ± 10% of the Billed Amount as follows: (a) the system takes the higher of the billed amounts and multiplies it by 10%; (b) it then subtracts the 10% figure from the higher amount resulting in a 90% of the higher billed amount figure; (c) the system then compares the lower billed amount from the other claim(s) to the 90% figure; (d) the lower billed amount(s) must be ≥ 90% of the higher billed amount.

2.2. Match Criteria for Non-institutional Claims

The following categories of match criteria are used to identify and link two or more matched non-institutional claims. Figure 11-3-2, Data Field Match Criteria for Non-Institutional Claims (on the following page), shows the specific HCSR data field match criteria used to select potential non-institutional duplicate claims.

Exact Match — All 14 fields match.

Near Match — Seven fields match and the lesser Billed Amount is within 10 percent of the larger Billed Amount.

CPT-4 Code Match — Six fields and the first three characters of the procedure code match.

Other — Six fields match.

FIGURE 11-3-2 DATA FIELD MATCH CRITERIA FOR NON-INSTITUTIONAL CLAIMS

FIELD NAME	EXACT MATCH	NEAR MATCH	CPT-4 CODE	OTHER
CLAIM LEVEL				
SPONSOR SSAN	✔	✔	✔	✔
DEERS DEPN SUFFIX	✔	✔	✔	✔
PATIENT DOB	✔			
PROGRAM INDICATOR	✔			
PROVIDER TAX ID	✔	✔	✔	✔
PROVIDER SUB ID	✔	✔	✔	✔
PRIN DIAGNOSIS	✔			
LINE ITEM LEVEL				
PLACE OF SERVICE	✔			
TYPE OF SERVICE	✔			
CARE BEGIN DATE	✔	✔	✔	✔
CARE END DATE	✔	✔		
BILLED AMOUNT	✔	+ / - 10% *	✔	
ALLOWED AMOUNT	✔			
PROCED CODE	✔	✔	posn 1-3	✔

NOTE: * The system calculates ± 10% of the Billed Amount as follows: (a) the system takes the higher of the billed amounts and multiplies it by 10%; (b) it then subtracts the 10% figure from the higher amount resulting in a 90% of the higher billed amount figure; (c) the system then compares the lower billed amount from the other claim(s) to the 90% figure; (d) the lower billed amount(s) must be ≥ 90% of the higher billed amount.

2.3. Exclusions

2.3.1. Exclusion of Certain Claims

The Duplicate Claims System excludes claims from the extract if they do not meet specific minimum dollar thresholds and other criteria. An individual claim is excluded if:

2.3.1.1. The Government paid amount at the claim level is $0.00.

2.3.1.2. The total allowed amount is less than $30.00.

2.3.1.3. The claim's program indicator is 'D' (Drug).

2.3.1.4. The claim's type of submission code is 'B', 'D', 'E', or 'O' (adjustment or cancellation to a prior non-HCSR claim or 100% paid by other health insurance).

2.3.1.5. The claim level allowed amount on a not at-risk institutional potential duplicate is less than $30.00.

2.3.1.6. The claim level allowed amount on an at-risk institutional potential duplicate is less than $50.00.

2.3.1.7. The sum of the line item level allowed amounts on a not at-risk non-institutional potential duplicate is less than $30.00.

2.3.1.8. The sum of the line item level allowed amounts on an at-risk non-institutional potential duplicate is less than $50.00.

2.3.2. Exclusion of Certain Line Items

The Duplicate Claims System excludes line items from the extract if the line item procedure code (CPT-4) is one of the following:

06888	Nutrition Equipment/Supplies - Purchase
06942	Other Equipment/Supplies - Purchase
76499	Radiographic Procedure
84999	Unlisted Chemistry Procedure
88305	Tissue Exam By Pathologist
90593	Whole Blood Charges
90594	Professional Components Charge
90595	Outpatient Hospital - Physician's Charge
90596	Outpatient Hospital - Recovery Room Charge
90597	Outpatient Hospital - Operating Room Charge
90599	Outpatient Hospital - Emergency Room Charge
90782	Injection (SC)/(IM)
90784	Injection (IA)
94799	Therapeutic/Diagnostic Injection
99070	Special Supplies
99088	Outpatient Hospital - Other Charges
99592	Hospital Outpatient Birthing Room Charges

2.3.3. Other Exclusions

After potential duplicate claims have been identified and grouped into claim sets, a final test is applied to exclude certain types of claim sets least likely to contain actual duplicate claims. Claim sets are excluded if they meet any of the following conditions:

2.3.3.1. The claim set contains less than two claims after the elimination of claims in the set due to any of the previously listed exclusion criteria.

2.3.3.2. The set is a "Mother-Baby" claim set and contains no more than two claims, where one claim has a "6..." series principal diagnosis code (mother) and the other claim has a "V..." series principal diagnosis code (baby). (Applies only to institutional claims.)

2.3.3.3. The set is a "Pseudo" DEERS Dependent Suffix (DDS) claim set and contains no more than two claims, where the DDS on both claims is '75' and the names on the claims are not the same.

2.3.3.4. The set is a "Multiple Birth" claim set and contains no more than two claims, where both claims have "V31..." through "V39..." series principal diagnosis codes. (Applies only to institutional claims.)